

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-008637

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2357

SL-27 FILED MAR 7 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN ST. LOUIS, MISSOURILength of stay in 1b
17 DAYSc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION VAH, 915 NO. GRAND AVE.Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTYc. CITY
OR
TOWN MADISONInside Limits
Yes ☒ No ☐d. STREET
ADDRESS 108 HILL STREETReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

ANTHONY ROBB

4. DATE
OF
DEATH

Month

Day

Year

2/26/62

5. SEX
MALE6. COLOR OR RACE
NEGRO7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐8. DATE OF BIRTH
3/11/909. AGE (last birthday)
71IF UNDER 1 YEAR
Months DaysIF UNDER 24 HR
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED STEEL WORKER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
POCAHANTUS, MISSOURI12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

JOSEPH C. ROBB

13b. MOTHER'S MAIDEN NAME

SARAH JAMES

14. NAME OF HUSBAND OR WIFE
- - - - -15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) If yes, give war or dates of service
YES WW-I

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

VERNON ROBB (SON) SEE #2

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

THROMBOEMBOLISM RT. PULMONARY ARTERY

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

BILATERAL ADRENAL HYPERPLESIA, MARKED

DUE TO (c)

274X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY
Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

2/9/62

to

2/26/62

and last saw him

2/26/62

Death occurred at

8:15 AM

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

SANFORD WOLFSON M.D.

VAH, ST. LOUIS, MO.

2/26/62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE

3/2/62

23c. NAME OF CEMETERY OR CREMATORY

National

23d. LOCATION (City, town, or county)

Jefferson Barracks, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Marshall Funeral Home-E.St.Louis, Ill.

25. DATE RECD. BY LOCAL REG.

FEB 28 1962

26. REGISTRAR'S SIGNATURE

H. Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Thomas M. Robson

Licensed Embalmer No. 4479

P. O. Address East St. Louis, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.